

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/04/16</p> <p>Facility Number: 000304 Provider Number: 155525 AIM Number: 100266810</p> <p>At this Life Safety Code survey, Shady Nook Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a basement was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 68 at the time of this</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0038 SS=E Bldg. 01	<p>survey.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 first floor exit accesses with stairs was provided with handrail. LSC 7.2.2.4.2 requires stairs and ramps shall have handrails on both sides. In addition, handrails shall be provided within 30 inches of all portions of the required egress width of stairs. The required egress width shall be provided along the natural path.</p> <p>Exception No 3: Existing stairs, existing ramps, stairs within dwelling units and within guest rooms, and ramps within dwelling units and guest rooms shall be permitted to have a handrail on one side only. This deficient practice could affect 18 residents who reside on the B Street Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 10/04/16 at</p>	K 0038	<p>* Corrective Action: A handrail will be installed according to the LSC requirements at the Emergency Exit Ramp on the B Street wing of the facility so the exit is readily accessible at all times.</p> <p>* Effects of other potential residents: There were no adversely affected residents found. The protective measure will be for the benefit of all residents to ensure their safety.</p> <p>*Measures for systemic change: To in-service maintenance staff on the importance of proper handrail installation and continued maintenance of these handrails that exist for resident safety.</p> <p>* Monitoring of corrective action: The Director of Maintenance will conduct a weekly check for six months to see that the newly installed handrail remains intact. These results will be reported to the HFA on a monthly basis and the report will be provided to QA on a quarterly basis. The IDR is being requested due to the fact that the building was</p>	11/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2016	
NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K 0046 SS=F Bldg. 01	<p>11:40 a.m., the B Street Hall exit had a sloping sidewalk leading to the parking lot with no handrail along the sidewalk path. Based on an interview with the maintenance supervisor on 10/04/16 at 11:45 a.m. it was stated the one hundred foot sidewalk had approximately ten feet of fall from the parking lot to the facility. The lack of handrail along the B Street exit sidewalk leading from the facility to the parking lot was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/04/16 at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.</p> <p>Based on record review and interview, the facility failed to ensure 3 of 14 battery backup lights were tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required</p>	K 0046	<p>just purchased by a new owner November 1, 2015. The surveyor cited that he'd tagged the building sometime prior for this handrail to be installed and instructed the Maintenance Director at that time to do so. That would've had to have been at least 4 to 5 years prior. The current HFA has been with the facility about 4 years & 2 months, and the Maintenance Director that was instructed to install the handrail has been away from the facility for 4 years. Consequently no one was aware of this need given the history of the facility/surveys so the new owner feels under the above circumstances this could've been a recommendation.</p> <p>* Corrective Action: A maintenance log that correlates with the Crossman Emergency/Exit Light Report according to Crossman Life & Safety will be developed for the facility maintenance department. * Effects of there potential residents: There were no adversely affected residents found. The protective measure will be for the benefit of all residents to ensure their safety.</p>	11/03/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 10/04/16 at 10:55 a.m. with the maintenance supervisor, the Shady Nook Care Center Battery operated Emergency Lights Monthly Test Log for the Year 2016 listed three additional battery powered emergency lights than the annual 90 minute Emergency/Exit Light Report from Crossman Fire & Safety Inc. dated 6/7/16. Furthermore the three additional battery backup lights not listed on the annual 90 minute test report were located at Kitchen-2, Kitchen-3, and the C Street Hall shower room. The lack of an annual 90 minute test on the battery backup lights located at the Kitchen-2, Kitchen-3, and C Street Hall shower room was verified by the maintenance supervisor at the time of record review</p>		<p>* Measures for systemic change: The maintenance department will be in-serviced on the importance of the coordination of the battery backup lights with the annual 90 minute Emergency/Exit Light Report from Crossman Fire & Safety, in effect that "all" lights are then tested in the emergency lighting system for the 30 day interval testing.</p> <p>* Monitoring of corrective action: A new maintenance log to include all lights will be implemented for the maintenance department. The HFA will monitor this testing and will turn in a report at the quarterly QA meetings.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0050 SS=F Bldg. 01	<p>and acknowledged by the administrator at the exit conference on 10/04/16 at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to conduct quarterly fire drills on all shifts for 1 of 4 quarters over the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports with the maintenance supervisor on 10/04/16 at 10:30 a.m., there was no fire drill documentation for the third shift, third quarter of the year 2016. Additionally, based on interview with the</p>	K 0050	<p>* Corrective Action: All maintenance records will be maintained according to the Life Safety Standard of K 050. This is to include quarterly drills on the equivalent of 3 shifts.</p> <p>* Effects of other potential residents: There were no adversely affected residents found. The protective measure will be for the benefit of all residents to ensure their safety.</p> <p>* Measures for systemic change: The maintenance department will be in-serviced on the importance of holding fire drills on the equivalent of 3 shifts, even though most scheduling involves only 2 shifts.</p>	11/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2016	
NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>maintenance supervisor during the review of the Fire Drill Report, there was no other documentation available for review to verify this fire drill was conducted. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 10/04/16 at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 3 of 4 first shift and 3 of 4 second shift fire drills were held at varying times over the past year to protect 68 of 68 resident. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on a review of the Fire Drill Reports with the maintenance supervisor on 10/04/16 at 10:30 a.m., the Fire Drill Reports for first shift and second shift were held at the following similar times over the past year; 10/18/15 at 6:20 p.m., 07/25/16 at 7:10 p.m., 04/25/16 at 7:00 p.m., 12/21/15 at 10:55 a.m., 09/30/16 at 10:54 a.m., 03/23/16 at 11:00 a.m. Based on an interview with the maintenance supervisor and written on each Fire Drill Report, the first shift time runs from 6:00</p>		<p>* Monitoring of corrective action: The HFA will monitor the fire drills on a monthly basis and will report to QA on a quarterly basis for these findings.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2016
NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 0067 SS=F Bldg. 01	<p>a.m. to 6:00 p.m. and the second shift time runs from 5:00 p.m. to 12:30 a.m. The similar timed fire drill records were acknowledged by the administrator at the exit conference on 10/04/16 at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 47 of 47 resident rooms. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the</p>	K 0067	<p>* Corrective Action: Due to the age and construction of the building an application for a waiver to grandfather the exception of this tag is being submitted (this waiver has been in effect since the early 1990's) since it would be cost prohibitive to attempt to comply with this standard. The request form and supporting documentation has been attached to this request.</p> <p>* Effects of other potential residents: There were no adversely affected residents found.</p> <p>* Measures for systemic change: N/A</p> <p>*Monitoring of corrective action: N/A</p>	11/03/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0144 SS=F Bldg. 01	<p>maintenance supervisor on 10/04/16 during the tour of the facility from 10:11 a.m. to 2:15 p.m., all resident rooms were using the egress corridor as a return air system. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 10/04/16 at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator alarm annunciator was provided with the requirements listed in NFPA 99. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall</p>	K 0144	* Corrective Action: 1) A consultant from GPS visited the facility on Wednesday October 12th. to check the generator about the concern with the digital panel on the annunciator and the information it is currently providing. The consultant is to get back with these recommendations for the resolution of this issue and corrections that are to be made according to his recommendations. 2) As for the record review of weekly inspections for the generator the facility had been maintain the required records, but unfortunately had been misfiled	11/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2016	
NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicate:</p> <ol style="list-style-type: none"> When the emergency or auxiliary power source is operating to supply power to load. When the battery charger is malfunctioning. <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> Low lubricating oil pressure. Low water temperature. Excessive water temperature. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. Overcrank (failed to start). Overspeed. <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 10/04/16 at 2:00 p.m. with the maintenance supervisor, the</p>		<p>by the maintenance fill-in (due to absence of Maintenance Director) and it was not in the regular Survey Maintenance Manual, but instead filed elsewhere. HFA had informed LSC surveyor of finding the misfiled log (please see attachment).</p> <p>* Effects of other potential residents: There were no adversely affected residents found. The protective measure will be for the benefit of all residents to ensure their safety.</p> <p>* Measures for systemic change: HFA will follow-up to see that the proper messaging of the annunciator panel for the generator is updated according to code. HFA will also in-service the maintenance department on the use of the annunciator, proper generator logs, and where they are to be kept.</p> <p>* Monitoring of corrective action: The HFA will monitor the generator annunciation panel and the generator weekly logs. A report will be made at QA meetings on a quarterly basis.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>emergency generator alarm annunciator, located at the nurses' station between the D Street Hall and the Alzheimer Hall, had a digital display panel. Furthermore, the digital display panel was scrolled through by the maintenance supervisor at the time of observation and the annunciator lacked an indication for low lubricating oil pressure, low water temperature, excessive water temperature, Overcrank and Overspeed. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/04/16 at 2:15 p.m.</p> <p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 4 of the past 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 6-4.1 requires Level 1 and Level 2 EPSS, including all appurtenant</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155525	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 36 VALLEY DR LAWRENCEBURG, IN 47025
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>components, shall be inspected weekly and shall be exercised under load monthly at a minimum. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 10/04/16 at 10:50 a.m., there was no record of weekly storage battery tests and weekly inspections of the generator set for the months of September 2016. Additionally, based on an interview during the record review, the maintenance supervisor stated there was no other documentation available for review to verify the weekly generator inspections for September 2016 were conducted. This was acknowledged by the administrator at the exit conference on 10/04/16 at 2:15 p.m.</p> <p>3.1-19(b)</p>			